Volume 11, Issue 3

BUREAU TALK

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Bureau Changes

It is with regret that the Bureau of Home Care and Rehabilitative Standards has said good-bye to two of our employees.

Effective June 30th, Edna Nelsen, Health Facility Nursing Consultant, who was the nurse surveyor in the southwest region of the state, resigned to take a nursing position in the private sector. We will sure miss the hospice and home health expertise Edna brought to the team.

Effective June 16, David Atkinson, Administrative Office Support Assistant, resigned from the bureau due to a promotion within the Department of Health and Senior Services. David worked very closely with many agencies ' staff regarding various agency issues. Please let any of your staff who contacts David on a regular basis know he is no longer with the bureau. We will not only miss David for his hard work but also his wit and charisma.

Please join us in wishing Edna and David the best in their new positions.

On a happier note, Deb Green, Office Support Assistant, has accepted the position of Administrative Office Support Assistant. Deb has been a member of the Bureau of Home Care and Rehabilitative Standards ' team for 3 years. Deb has been the main person answering the bureau 's phones, has done all the state licensing for all the agencies, and many other day to day duties. Please join us in congratulating Deb on her promotion.

Cigna Government Services (CGS)

Effective June 1, 2011, CIGNA Government Services is now called CGS, LLC. With this change, their web-site address is now http://www.cgsmedicare.com/.

All the same services, features, education, addresses, telephone numbers, and claim submission processes remain exactly the same – only the name changed. Converting all of the communication will take some time so it is very important for providers to open and respond to all communication you receive whether it is addressed from CGS or the former name of CIGNA Government Services.

The Home Health & Hospice Region B workload transitioned from Cahaba GBA to CGS on June 13, 2011 as part of the Jurisdiction 15 A/B MAC implementation.

Following are the contacts for CGS:

Provider Enrollment Home Health	1-877-299-4500
Provider Enrollment Hospice	1-866-539-5592
Provider Enrollment Correspondence	PART A/HHH Provider Enrollment CGS 1 Cameron Hill Circle STE 0063 Chattanooga, TN 37402-0063

Plans of Corrections

The Bureau would like to remind providers of what an acceptable plan of correction (POC) should contain. It must:

- Address what the agency will do to "systematically" correct the deficient practice; explain the processes that will be corrected in order to keep this from happening in the future;
- Explain for each specific deficiency, what will be implemented to correct the deficiency;
- Contain a separate POC for each deficiency;
- Specify one single correction date for implementation of the corrective actions for each of the deficiencies cited. Do not use multiple completion dates;
- Define specific steps to correct the problem, stating exactly how the deficiency was or will be corrected;
- Explain how the agency plans to be "proactive" instead of "retroactive";
- Outline the monitoring procedure to ensure that the POC is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- Identify one person by title to monitor and provide oversight of the entire plan of correction.

Plans of Corrections Cont.

A second reminder to providers pertaining to the plans of corrections is the issue of confidentiality. All Statement of Deficiencies and Plans of Corrections are posted to the Show Me Home Care and Rehab website. The public have access to this website; therefore, the public will have access to any information submitted with the plan of correction. Do not send any patient or employee identifiable information. Do not use any personal names or financial information on the plan of correction.

Expansion of Agency Geographic Area

The bureau has recently updated and changed the policy on expansion of agency geographic territory. Home health and hospice agencies may request, in writing, the expansion of the agency's geographic service area. Upon receipt of a request for expansion, the bureau will send a questionnaire to the agency for them to clarify the planned administration and supervision of the expanded territory. The bureau must receive this additional information within 60 days, or the expansion request will be withdrawn.

Following are a few of the stipulations required before a request can be granted (non-inclusive):

- The agency must be in compliance with the conditions of participation (No deficiencies out).
- Counties/area for expansion requested by the agency must be contiguous to counties/areas already approved.
- An agency cannot expand from one metropolitan or micropolitan statistical area to another. A map of the statistical areas in Missouri can be found at **http://www.missourieconomy.org/indicators/population/msa-2003.stm**
- There must be evidence from the agency's annual statistical report for the previous year, that the agency has served patients in their already approved counties adjacent to those requested.
- New home health agencies or hospices must be in operation for at least one year following the initial survey before expansion of approved counties will be considered.
- After approval of expanded geographic territory, further expansion requests will not be considered or granted for a one year period from the approval date.

Websites

The Department of Health and Senior Services (DHSS) website was updated in February 2011. The new department website address is http://www.health.mo.gov. To get to the bureau's website from DHSS webpage, you will need to click on *"Licensing and Regulations"* and then on *"Home Care" or "Hospice"*. The easiest direct access to the Bureau of Home Care & Rehabilitative Standards' website is http://www.health.mo.gov/safety/homecare.

Home Health Issues

New Survey Process

As stated in the April 2011 Bureau Talk, effective May 1, 2011, CMS implemented the new survey process. All home health surveys completed after this date have been conducted using the new survey protocol. Due to the new survey process there may be at least 2 surveyors conducting the survey. For larger agencies, there could be as many as 4 surveyors.

To view the Advance Copy of Appendix B of the State Operations Manual, Part I – Investigative Procedures and Part II – Interpretive Guidelines, please refer to Survey and Certification Memo dated February 11, 2011 (S&C: 11-11-HHA). See **ATTACHMENT A.**

The Home Health Agency (HHA) Survey Protocol webinar originally presented on April 6, 2011 to all federal surveyors is now posted for the general public at: https://webinar.cms.hhs.gov/hhasurvey

A brief summary of the new home health survey process follows:

- There are Level 1 and Level 2 Standards
  - A. Level 1:
    - a. Level 1 standards are considered the highest priority standards. These regulations are most related to high-quality care and comprise the standard survey.
    - b. There are 34 level 1 tags. Instead of reviewing 115 tags as part of a standard survey as with the old process, only 34 tags are now initially reviewed. If there is no deficiency with those 34 tags, CMS has determined it is highly likely the agency is in compliance with all CoPs.
    - c. Level 1 standards address 9 of the 15 CoPs. (Patient Rights, Compliance with Laws, Organization, Services, & Administration, Acceptance of Patients, POC and Medical Supervision, Skilled Nursing, Therapy, Home Health Aides, Clinical Record and Comprehensive Assessment)
    - d. Skilled nursing and therapy are Level 1 standards are now part of the standard survey.

New Survey Process Cont.

B. Level 2:

a. Level 2 standards are considered the next highest priority standards. These regulations comprise the partial extended survey.

b. The partial extended survey is conducted when a standard level non-compliant finding is identified in a Level 1 standard **and/or** any other deficient practice is found.

c. During a partial extended survey, the surveyor reviews, at a minimum, the level 2 standards under the same condition which are related to the Level 1 standards out of compliance.

- Extended Survey:

a. Consists of a review of **all conditions**.

b. The extended survey may be conducted at any time at the discretion of CMS or the state agency and **must** be conducted when **any** condition level deficiency is found. When any CoP is identified to be out of compliance, all 15 conditions are reviewed, including all 163 standards that fall under the home health regulations.

c. This survey also reviews the HHA's policies, procedures, and practices that produced the substandard care, which CMS defines as one or more condition-level deficiencies.

- CMS has directed surveyors that, because the Level 1 highest priority standards are identified as those most related to the delivery of high-quality care, **a single problematic finding with an actual (or potential) poor outcome(s)** would support a determination of noncompliance with a standard tag (e.g., one clinical record finding and/or one home visit finding). In other words, surveyors no longer need to see a "trend" to cite a deficiency.

- CMS has laid out specific criteria as to when to cite condition-level deficiencies.

- There is an increase in the information gathered from staff interviews

- There is a decrease in the number of record reviews

New Survey Process Cont.

- There is a decrease in the number of record reviews

Number of Unduplicated Admissions	Old Number of Record Reviews	New Number of Record Reviews
<150	11	10
150 - 750	15	12
751 - 1250	19	16
1251 or more	25	10

- There is an increase in the number of home visits

Number of Unduplicated Admissions	Old Number of Home Visits	New Number of Home Visits
<150	3	5
150 – 750	5	6
751 – 1250	7	8
>1251	25	10

Hospice Issues

Bereavement

Per state regulation, 19 CSR30-35.010 (2)(G)(5)(B) Bereavement Care Services, "Within two months following the patient's death, there shall be an assessment of risk of the bereaved individual and a plan of care that extends for one year appropriate to the level of risk assessed."

It is the expectation of the bureau that this two-month visit be in person.

At the request of the Missouri Hospice and Palliative Care Association, Judy Morris, state surveyor, recently gave a presentation on "Bereavement" to a group of bereavement coordinators. In discussing Judy's presentation, it was stated by the group that most patient's family tend to refuse the 2 month bereavement visit.

The bureau would like to stress that the majority of these families should not be refusing this visit. If this is a common occurrence, the hospice agency should be evaluating how they are presenting the request to the families to make these visits.

Please see **Attachment B** for an outline of Judy's presentation.

Bill of Rights

Although the new federal hospice regulations have been in effect for almost 3 years now, the surveyors have noticed on survey that many agencies have not yet updated their documentation on the patient's bill of rights; therefore, many citations are being written. CFR 418.52, Condition of Participation: Patient's Rights now has 19 standard tags under that one condition. To ensure compliance with these regulations, please take the time to review these regulations and update your documentation accordingly.

Division of MO Healthnet

The bureau frequently receives inquiries regarding whom providers can contact regarding issues with Medicaid hospice patients. If you should have any questions regarding Medicaid hospice guidelines please contact Kim Johnson at 573-751-7988.

One Hour Response Time

In response to commentary submitted by the Missouri Hospice & Palliative Care Association (MHPCA) board, and a meeting with representatives from the MHPCA Regulatory Affairs Committee and the bureau's Hospice Advisory Council, the bureau has revised the guidance on one-hour response to emergent patient needs published in Bureau Talk, Volume 11, Issue 2, April 2011.

The bureau understands that hospices' primary emergent response, both during and outside normal office hours, will be a nursing response. This is because most emergent needs require nursing intervention. Therefore, it is the bureau's expectation that hospices maintain adequate staffing to assure that a nurse is available to respond to emergent patient needs within one hour of the identification of that need at all locations within the hospice's service area.

The hospice must demonstrate the ability to provide one-hour emergent nursing response twenty-four hours a day. The agency's policy must define access to all of the service area during that 24-hour period. During a survey, the burden of proof will be on the hospice to assure compliance with 19 CSR 30-35.010 (1)(H)(3). Hospices, whose nurses live in two separate ends of the service area, must demonstrate that on-call and back-up coverage is sufficient that if the nurse who lives closest to the patient with an emergent need is not available to respond, another nurse is available who can respond within one hour.

The hospice's policy must also address how the agency will respond if on arrival at the patient's residence, the nurse assesses that the presenting need is best met through social worker or chaplain interventions. Agency policy will also clearly state the patient and caregiver's role in defining emergent versus non-emergent need: if patient or caregiver states that the need is emergent, it is.

Statistical Reports

This is just a "heads-up" to hospice providers that the statistical report for 2011 will have a couple changes. The Missouri Hospice Advisory Council has requested that the statistical reports begin capturing the number of veterans and pediatric patients (ages 0-12yrs). Therefore, when the statistical reports come out at the end of this year, you will see the request for this information.

OASIS Clinical by Joyce Rackers

Quarterly Q&As

Since the last publication of the Bureau Talk, there have been two new sets of OCCB Quarterly Q&A's published. Please go to www.oasiscertificat.org to access the April 2011 First Quarter and July 2011 Second Quarter Q&As.

Some highlights (non-inclusive) from these Q&As are:

What to do with the OASIS when the Face-to-Face is not performed as required by the fiscal intermediary?

M1012 – any response is insignificant; any response is acceptable.

M1342 – With implementation of OASIS C, "0-Newly epithelialized" was added as an available response for M1342; therefore, changing the guidance given in previous CMS Q&A 108.1.

How to answer M1510 if the physician calls the patient back, not the agency

For M2015, "other healthcare provider" includes a pharmacist but there are special requirements

M2100 – what does "Assistance needed, but no caregives(s) available" really mean?

M2250a – There was an error in the updated Guidance manual and the December 2010 errata sheet. If the agency uses their own agency standardized guidance, which the physician has NOT agreed to include in the plan of care for this particular patient, the response on the Plan of Care Synopsis should be "NA" instead of "No".

OASIS corrections when assessing clinician is no longer available

New guidance for scoring stasis ulcers and surgical wounds

Clarifications on multi-factorial fall risk assessments.

New Reporting Matrix

CMS has again revised the OASIS-C Reporting Transition Matrix. The latest version was updated 4/13/11. Please see **Attachment C**.

OASIS TRAINING

CMS has recently posted an online OASIS training module titled, "The Medication Module". This module is focused on OASIS-C questions that relate to medications. It reviews OASIS items M2000 through M2040 providing for OASIS accuracy. Please consider using this training module in your agencies for staff education. You can access this training module by going to http://surveyortraining.cms.hhs.gov/index.aspx under the "Provider Tools" tab.

OASIS Automation by Debi Siebert

Notice: H@ Login Procedure Changing

CMS is transitioning the CMSNet connectivity from AT&T to Verizon. This transition will affect your h@ login ID and will stream line the steps to connect. Your login ID for all other accounts (CASPER Login ID and State Login ID) will not be affected. The CMSNet migration will be completed by the end of CMS' Fiscal Year 2011. A migration schedule for providers will be posted as soon as it becomes available. In the mean-time, continue to connect as normal until further instructions are posted.

Detailed information will be posted on the CMSNet pages of the QTSO Web Site as it becomes available. The CMSNet link is located in the top right corner of the QTSO Home page. Please continue to check the QTSO Web site frequently for updates.

https://www.qtso.com (homepage)

https://www.qtso.com/cmsnet.html (user ID and connectivity information)

Notice: OASIS Providers with One Registered User

A large number of OASIS providers have only one user registered with a personal login ID. The personal login ID is non-transferrable. If the registered user's employment is terminated, the provider is left without the appropriate access to assessment submission and CASPER Reporting applications. To alleviate the potential for gaps in processing, it is strongly recommended that each provider have two registered users.

Home Health Agency (HHA) State-Assigned User IDs and Passwords

With the implementation of HHA individual user IDs, there has been confusion as to whether or not the State is allowed to provide agencies with a state-assigned user ID and password. State-assigned user IDs and passwords are critical for agencies using Corporate and Third Party entities for report creation and retrieval in the CASPER Reporting application.

Corporate and Third Party individual user IDs are not structured with the appropriate credentials to access HHA provider reports in CASPER Reporting; those users must use a state-assigned user ID and password to access CASPER Reports, and depend on the agencies to provide them that information.

States can provide information related to state-assigned user IDs and passwords using whatever verification methods they used before HHA individual user IDs were implemented. States are expected to provide their agencies with state-assigned user IDs and passwords. The agencies will then be responsible for providing that information to Corporate and/or Third Party Service Bureau users.

OASIS Quality Improvement Report Category

The following reports are now available within the OASIS Quality Improvement report category in CASPER:

- Outcome Risk Adjusted 2 Report
- Outcome Risk Adjusted 2 Report - Text
- Outcome Risk Adjusted 3 Report
- Outcome Risk Adjusted 3 Report - Text
- Potentially Avoidable Event Patient Listing Report
- Potentially Avoidable Event Risk Adjusted 2 Report
- Potentially Avoidable Event Risk Adjusted 2 Report - Text
- Potentially Avoidable Event Risk Adjusted 3 Report
- Potentially Avoidable Event Risk Adjusted 3 Report - Text
- Tally: Outcome

OASIS-C Quality Improvement Category

Additionally the packages available with the OASIS C Quality Improvement category have also been updated to include the following reports:

Quality Improvement 2 CoI Package

- Outcome Risk Adjusted 2 Report
- Outcome Risk Adjusted 2 Report – Text
- Potentially Avoidable Event Patient Listing Report
- Potentially Avoidable Event Risk Adjusted 2 Report
- Potentially Avoidable Event Risk Adjusted 2 Report – Text

Quality Improvement 3 CoI Package

- Outcome Risk Adjusted 3 Report
- Outcome Risk Adjusted 3 Report – Text
- Potentially Avoidable Event Patient Listing Report
- Potentially Avoidable Event Risk Adjusted 3 Report
- Potentially Avoidable Event Risk Adjusted 3 Report – Text

Extended Roll-Off Period for OASIS Final Validation and OASIS Activity Reports

Effective May 26, 2011, OASIS Final Validation reports or OASIS Activity reports created on or after May 26 will be stored on the state server for 365 days. This change extends the roll-off period and allows Home Health Agencies more time to provide evidence to the Regional Home Health Intermediary（RHHI） that assessments were submitted, in order to avoid denial of claims during the medical review period. CMS strongly encourages agencies to print or save validation reports for future reference before the reports are rolled off the state server.

Reminder: Due to privacy and security concerns, always use certified mail to submit Final Validation reports to the RHHI.

Additional Information

Information on requesting the above reports is available in the OASIS C Quality Improvement section of the CASPER Reporting Users Manual located on the QIES to Success or the OASIS State Welcome Pages.